

6 Key Trends in Compensation of Hospital-Based Physicians

WRITTEN BY LEIGH PAGE | JUNE 30, 2010

While the care and feeding of hospital-based physicians is not a new topic, there are some new trends and strategies for this group, which includes anesthesiologists, radiologists, pathologists, emergency physicians and hospitalists. Here are six of those trends.

1. Trend toward employment. Hospitals have been moving away from contracting with independent groups for hospital-based services and toward physician employment. "The current trend is toward employment," says Kim Mobley, principal of Sullivan Cotter and Associates. Anesthesiology is a good example of this trend. While hospitals traditionally contracted with anesthesiology groups, 44 percent of anesthesiologists were salaried employees in 2009, while 32 percent were owners or partners in different types of practices and 19 percent were locum tenens or contractors, according to LocumTenens.com.

"Usually the hospital provides employment only when there are no other options," says Will Reiser, vice president of product development and decision support at Halley Consulting. This often happens because anesthesiologists are in short supply, though the recession has somewhat slackened demand for them.

Mr. Reiser says the employment model for anesthesiologists is particularly common in rural areas, where independent anesthesiology practices often cannot find enough volume to survive on their own reimbursed income. "The group approaches the hospital and says, 'Look, we can't make it on our own. We're going to need your help or we'll leave town,'" he says.

However, Mr. Reiser advises hospitals to buck the trend toward employment and continue outsourcing their anesthesiology services in most cases. "Employing anesthesiologists hasn't been a strategic advantage for hospitals," he says. Halley Consulting worked with a hospital that hired its independent group of anesthesiologists, hoping that the arrangement would cost less, but its anesthesiology costs didn't change much. "The hospital expected to get more control but anesthesiologists' time off actually increased," Mr. Reiser says.

2. Evolving payment formulas. Hospitals have been developing new and more complicated payment formulas, based on ever-richer data, such as relative value units (RVUs) and quality measures. Ms. Mobley says the variables used in determining a physician's base salary include specialty area, the physician's experience and credentials, the type of compensation approach and the amount of compensation that is at risk. In the past several years, she says, physicians' salaries have been tied to productivity, which is usually the base salary plus extra compensation based on productivity as measured by RVUs or, in the case of anesthesiologists, ASA units.

Some key factors to identify in the payment formula are the clinical services provided, any administrative services performed by the group and any call coverage, Ms. Mobley says. She identifies some other factors:

- Quality measures. "Many organizations are beginning to include elements of compensation that include some type of quality metric," Ms. Mobley says. Usually each organization designs its own quality metrics, which still tend to focus on process rather than outcomes.
- Strategic objectives. "As healthcare organizations move toward alignment, we have started seeing measures tied to strategic objectives of the organization or the service line," she says. \
- Professional fees. What is the group receiving in collections for professional services? Ms. Mobley says this is especially difficult to figure out in pathology because of bundled payments.

3. Paying hospitalists. Although some hospitalists are in large group practices that contract with hospitals, hospitalists tend to be employed by the hospital. Mr. Reiser says this is because hospitalist programs are often built from in-house internists who decide to switch careers.

"The problem with hospitalists is that at night and on weekends, they have nothing to do," Mr. Reiser says. "They work hard on the day shift, but at night they are starved for work, so a pure work RVU formula doesn't fit the model well," he says. "One way to handle this is a combination of an RVU for daytime work and paying them on an hourly basis shift work at night. Another way is to give them a minimum guarantee and if they work hard they get paid more." The minimum payment might be \$150,000 to \$160,000, then add a payment based on their RVU, he says.

Another method, Mr. Reiser says, is to balance productivity among a few providers. "Say you need four providers. Then structure compensation for that," he says. "This keeps them productive. Put the threshold level, the trigger, at the average number of RVUs expected." Above that they get extra. But he cautions that any push for greater workloads must be balanced by checking for quality. "You need to put in quality factors; you can't have overwhelmed doctors," Mr. Reiser says.

4. Paying emergency physicians. Ms. Mobley says emergency physicians tend to be paid like hospitalists. Hospitalists and emergency physicians do shift work, sometimes on an hourly basis, with incentives for production and quality, she says. In smaller facilities, emergency physicians may be employed by a 24/7 ED that contracts with the hospital, she says.

5. Radiologists and pathologists. Radiology and pathology payments usually involve a salary component, Ms. Mobley says. The salary component might amount to 60-75 percent of total pay, plus a productivity component of perhaps 25-30 percent and 5-10 percent for quality, she says. Mr. Reiser says the typical hospital needs only one pathologist, and the payment formula is straightforward because they don't need to be available around the clock.

6. Use of stipends. Contracted anesthesiology groups in particular have been asking hospitals for stipends to supplement their income. In a 2004 survey sponsored by the American Association of Anesthesiologists, 57 percent of the hospitals provided at least one type of stipend to their contracted anesthesiology group, up from about one-half in 2000. Negotiating can be a matter of clout. While 75 percent of larger anesthesiology groups were receiving stipends, only 38 percent groups with fewer than 10 providers did so.

Mr. Reiser cautions that groups who need stipends should have to demonstrate their need with data. "A business case analysis needs to be done, identifying the practice revenue and justifying it with data." Has the practice done all it can to optimize its billings and collections? Has it attempted to cut expenses without jeopardizing service or patient care? The practice must be willing to share its financial data, he says.

The federal anti-kickback law requires that payments to physicians should at the "fair market value," he says. The figure is based on surveys on physician income provided by groups like MGMA, AMGA and Sullivan Cotter. "It's a fairly wide definition, but if you are paying five, six, seven times what the service could generate, that would be out of line," Mr. Reiser says.

Both sides must agree on what services the stipends will cover. Services might include call coverage, medical directorships, participation in hospital committees, administrative duties or participation in process improvement initiatives. In the ASA survey, the most common anesthesiology stipends were for call coverage (35 percent), medical directorship (33 percent), general obstetrical (28 percent) and trauma (21 percent), while 20 percent of stipend arrangements involved income guarantees, an emerging trend.

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